# State of California
# Office of Administrative Law

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|---|---|
| **In re:**<br>**California Health Benefit Exchange**<br><br>**Regulatory Action:**<br><br>**Title 10, California Code of Regulations**<br><br>**Adopt sections: 6460**<br>**Amend sections:**<br>**Repeal sections:** | **NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION**<br><br>**Government Code Sections 11346.1 and 11349.6**<br><br>**OAL File No. 2014-1107-05 EE** |

The California Health Benefit Exchange (HBEX) submitted this emergency readopt action to maintain the regulations adopted in OAL file no. 2014-0512-01E, which added section 6460 to title 10 of the California Code of Regulations. Section 6460 incorporates by reference the 2015 Standard Benefit Plan Designs, which standardize the way health insurance issuers design their health plans.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 11/17/2014 and will expire on 5/22/2016. The Certificate of Compliance for this action is due no later than 5/21/2016.

Date: 11/17/2014

Lindsey McNeill
Attorney

For: DEBRA M. CORNEZ
Director

Original: Peter Lee
Copy: Brandon Ross

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

# EMERGENCY

# NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

ENDORSED FILED
IN THE OFFICE OF
2014 NOV 17 PM 1:52
DEBRA BOWEN
SECRETARY OF STATE

STD. 400 (REV. 01-2013)

| OAL FILE NUMBERS | NOTICE FILE NUMBER | REGULATORY ACTION NUMBER | EMERGENCY NUMBER |
|---|---|---|---|
| | Z- | | 2014-1107-05EE |

For use by Office of Administrative Law (OAL) only

2014 NOV -7 PM 4:10
OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

## A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

| 1. SUBJECT OF NOTICE | TITLE(S) | FIRST SECTION AFFECTED | 2. REQUESTED PUBLICATION DATE |
|---|---|---|---|
| | | | |

| 3. NOTICE TYPE | 4. AGENCY CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional) |
|---|---|---|---|
| ☐ Notice re Proposed Regulatory Action ☐ Other | | | |

| OAL USE ONLY | ACTION ON PROPOSED NOTICE | NOTICE REGISTER NUMBER | PUBLICATION DATE |
|---|---|---|---|
| | ☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn | | |

## B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): 2015 Standard Benefit Design

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2014-0512-01E

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

| SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.) | ADOPT: 6460 |
|---|---|
| | AMEND: |
| TITLE(S): 10 | REPEAL: |

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify)
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

| 7. CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional) | E-MAIL ADDRESS (Optional) |
|---|---|---|---|
| Brandon Ross | 916-228-8281 | | brandon.ross@covered.ca.gov |

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: [signature] DATE: 11/6/14

TYPED NAME AND TITLE OF SIGNATORY: Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
NOV 17 2014
Office of Administrative Law

**Adopt Section 6460, which is all new regulation text to be added, to read:**

## SECTION 6460: 2015 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2015, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2015 Standard Benefit Plan Designs, dated April 17, 2014, which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

# 2015 Standard Benefit Plan Designs

April 17, 2014

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

COVERED CALIFORNIA™

## Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Platinum Coinsurance Plan | Platinum Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 88.10% | 88.00% |
| Individual Overall deductible | $0 | $0 |
| Other individual deductibles for specific services | | |
| Medical | $0 | $0 |
| Brand Drugs | $0 | $0 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $4,000 | $4,000 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $20 | | $20 | |
| | Specialist visit | | $40 | | $40 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $20 | | $20 | |
| | X-rays and Diagnostic Imaging | | $40 | | $40 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | $150 | |
| Drugs to treat illness or condition | Generic drugs | | $5 | | $5 | |
| | Preferred brand drugs | | $15 | | $15 | |
| | Non-preferred brand drugs | | $25 | | $25 | |
| | Specialty drugs | | 10% | | 10% | |
| Outpatient surgery | Facility fee (e.g., ASC) | | 10% | | $250 | |
| | Physician/surgeon fees | | 10% | | | |
| Need immediate attention | Emergency room services (waived if admitted) | | $150 | | $150 | |
| | Emergency medical transportation | | $150 | | $150 | |
| | Urgent care | | $40 | | $40 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 10% | | $250 per day up to 5 days | |
| | Physician/surgeon fee | | 10% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $20 | | $20 | |
| | Mental/Behavioral health inpatient services | | 10% | | $250 per day up to 5 days | |
| | Substance use disorder outpatient services | | $20 | | $20 | |
| | Substance use disorder inpatient services | | 10% | | $250 per day up to 5 days | |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 10% | | $250 per day up to 5 days | |
| | | Professional | 10% | | | |
| Help recovering or other special health needs | Home health care | | 10% | | $20 | |
| | Outpatient Rehabilitation services | | $20 | | $20 | |
| | Outpatient Habilitation services | | $20 | | $20 | |
| | Skilled nursing care | | 10% | | $150 per day up to 5 days | |
| | Durable medical equipment | | 10% | | 10% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | $25 | |
| Child Dental Major Services | Root Canal- Molar | | 50% | | $300 | |
| | Gingivectomy per Quad | | | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | $65 | |
| | Extraction- Complete Bony | | | | $160 | |
| | Porcelain with Metal Crown | | | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | | $1,000 | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Gold Coinsurance Plan | Gold Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 78.60% | 78.60% |
| Individual Overall deductible | $0 | $0 |
| Other Individual deductibles for specific services | | |
| Medical | $0 | $0 |
| Brand Drugs | $0 | $0 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | $30 | | $30 | |
| | Specialist visit | $50 | | $50 | |
| | Preventive care/ screening/ immunization | No cost share | | No cost share | |
| Tests | Laboratory Tests | $30 | | $30 | |
| | X-rays and Diagnostic Imaging | $50 | | $50 | |
| | Imaging (CT/PET scans, MRIs) | 20% | | $250 | |
| Drugs to treat illness or condition | Generic drugs | $15 | | $15 | |
| | Preferred brand drugs | $50 | | $50 | |
| | Non-preferred brand drugs | $70 | | $70 | |
| | Specialty drugs | 20% | | 20% | |
| Outpatient surgery | Facility fee (e.g., ASC) | 20% | | $600 | |
| | Physician/surgeon fees | 20% | | | |
| Need immediate attention | Emergency room services (waived if admitted) | $250 | | $250 | |
| | Emergency medical transportation | $250 | | $250 | |
| | Urgent care | $60 | | $60 | |
| Hospital stay | Facility fee (e.g. hospital room) | 20% | | $600 per day up to 5 days | |
| | Physician/surgeon fee | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | $30 | | $30 | |
| | Mental/Behavioral health inpatient services | 20% | | $600 per day up to 5 days | |
| | Substance use disorder outpatient services | $30 | | $30 | |
| | Substance use disorder inpatient services | 20% | | $600 per day up to 5 days | |
| Pregnancy | Prenatal care and preconception visits | No cost share | | No cost share | |
| | Delivery and all inpatient services — Hospital | 20% | | $600 per day up to 5 days | |
| | Delivery and all inpatient services — Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | 20% | | $30 | |
| | Outpatient Rehabilitation services | $30 | | $30 | |
| | Outpatient Habilitation services | $30 | | $30 | |
| | Skilled nursing care | 20% | | $300 per day up to 5 days | |
| | Durable medical equipment | 20% | | 20% | |
| | Hospice service | No cost share | | No cost share | |
| Child eye care | Eye exam | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | 20% | | $25 | |
| Child Dental Major Services | Root Canal- Molar | 50% | | $300 | |
| | Gingivectomy per Quad | | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | $65 | |
| | Extraction- Complete Bony | | | $160 | |
| | Porcelain with Metal Crown | | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | 50% | | $1,000 | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | | | Individual<br>Silver<br>Coinsurance Plan | | Individual<br>Silver<br>Copay Plan | |
|---|---|---|---|---|---|---|
| Actuarial Value - AV Calculator | | | 70.30% | | 69.90% | |
| Individual Overall deductible | | | N/A | | N/A | |
| Other Individual deductibles for specific services | | | | | | |
| | Medical | | $2,000 | | $2,000 | |
| | Brand Drugs | | $250 | | $250 | |
| | Dental | | $0 | | $0 | |
| Individual Out-of-pocket maximum | | | $6,250 | | $6,250 | |
| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | | $15 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | $25 | |
| Child Dental Major Services | Root Canal- Molar | | 50% | | $300 | |
| | Gingivectomy per Quad | | | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | $65 | |
| | Extraction- Complete Bony | | | | $160 | |
| | Porcelain with Metal Crown | | | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | | $1,000 | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

| **Summary of Benefits and Coverage**<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | **SHOP**<br>**Silver**<br>**Coinsurance Plan** | **SHOP**<br>**Silver**<br>**Copay Plan** |
|---|---|---|
| Actuarial Value - AV Calculator | 71.50% | 71.00% |
| Individual Overall deductible | N/A | N/A |
| Other Individual deductibles for specific services | | |
| Medical | $1,500 | $1,500 |
| Brand Drugs | $500 | $500 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | | $15 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | $25 | |
| Child Dental Major Services | Root Canal- Molar | | 50% | | $300 | |
| | Gingivectomy per Quad | | | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | $65 | |
| | Extraction- Complete Bony | | | | $160 | |
| | Porcelain with Metal Crown | | | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | | $1,000 | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | SHOP<br>Silver HSA Plan |
|---|---|
| Actuarial Value - AV Calculator | 71.60% |
| Individual Overall deductible | $1,500 integrated Med/Rx Ded |
| Other Individual deductibles for specific services | |
| Medical | N/A |
| Brand Drugs | N/A |
| Dental | N/A |
| Individual Out-of-pocket maximum | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | 20% | X |
| | Specialist visit | | 20% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | 20% | X |
| | X-rays and Diagnostic Imaging | | 20% | X |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| Drugs to treat illness or condition | Generic drugs | | 20% | X |
| | Preferred brand drugs | | 20% | X |
| | Non-preferred brand drugs | | 20% | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | 20% | X |
| | Emergency medical transportation | | 20% | X |
| | Urgent care | | 20% | X |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | 20% | X |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | 20% | X |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | X |
| Help recovering or other special health needs | Home health care | | 20% | X |
| | Outpatient Rehabilitation services | | 20% | X |
| | Outpatient Habilitation services | | 20% | X |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | X |
| | Hospice service | | No cost share | X |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | |
| Child Dental Major Services | Root Canal- Molar | | 50% | |
| | Gingivectomy per Quad | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | |
| | Extraction- Complete Bony | | | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**10.0 EHB**
**Date: April 17, 2014**

## Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Coinsurance Plan 100%-150% FPL | Silver Coinsurance Plan 150%-200% FPL |
|---|---|---|
| Actuarial Value - AV Calculator | 94.60% | 88.00% |
| Individual Overall deductible | $0 | N/A |
| Other individual deductibles for specific services | | |
| Medical | $0 | $500 |
| Brand Drugs | $0 | $50 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $2,250 | $2,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $3 | | $15 | |
| | Specialist visit | | $5 | | $20 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | 15% | X |
| Drugs to treat illness or condition | Generic drugs | | $3 | | $5 | |
| | Preferred brand drugs | | $5 | | $15 | X |
| | Non-preferred brand drugs | | $10 | | $25 | X |
| | Specialty drugs | | 10% | | 15% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 10% | | 15% | |
| | Physician/surgeon fees | | 10% | | 15% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $25 | | $75 | X |
| | Emergency medical transportation | | $25 | | $75 | X |
| | Urgent care | | $6 | | $30 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 10% | | 15% | X |
| | Physician/surgeon fee | | 10% | | 15% | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | | 10% | | 15% | X |
| | Substance use disorder outpatient services | | $3 | | $15 | |
| | Substance use disorder inpatient services | | 10% | | 15% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 10% | | 15% | X |
| | | Professional | 10% | | 15% | |
| Help recovering or other special health needs | Home health care | | 10% | | 15% | |
| | Outpatient Rehabilitation services | | $3 | | $15 | |
| | Outpatient Habilitation services | | $3 | | $15 | |
| | Skilled nursing care | | 10% | | 15% | X |
| | Durable medical equipment | | 10% | | 15% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | 20% | |
| Child Dental Major Services | Root Canal- Molar | | 50% | | 50% | |
| | Gingivectomy per Quad | | | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | | |
| | Extraction- Complete Bony | | | | | |
| | Porcelain with Metal Crown | | | | | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | | 50% | |

See endnotes.

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**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Coinsurance Plan 200%-250% FPL |
|---|---|
| Actuarial Value - AV Calculator | rounded up to 74.0% |
| Individual Overall deductible | N/A |
| Other individual deductibles for specific services | |
| Medical | $1,600 |
| Brand Drugs | $250 |
| Dental | $0 |
| Individual Out-of-pocket maximum | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $40 | |
| | Specialist visit | | $50 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| Drugs to treat illness or condition | Generic drugs | | $15 | |
| | Preferred brand drugs | | $35 | X |
| | Non-preferred brand drugs | | $60 | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | |
| Help recovering or other special health needs | Home health care | | 20% | |
| | Outpatient Rehabilitation services | | $40 | |
| | Outpatient Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | |
| Child Dental Major Services | Root Canal- Molar | | 50% | |
| | Gingivectomy per Quad | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | |
| | Extraction- Complete Bony | | | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | |

See endnotes.

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### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Copay Plan 100%-150% FPL | Silver Copay Plan 150%-200% FPL |
|---|---|---|
| Actuarial Value - AV Calculator | 94.90% | 88.00% |
| Individual Overall deductible | $0 | N/A |
| Other Individual deductibles for specific services | | |
| Medical | $0 | $500 |
| Brand Drugs | $0 | $50 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $2,250 | $2,250 |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | $3 | | $15 | |
| | Specialist visit | $5 | | $20 | |
| | Preventive care/ screening/ immunization | No cost share | | No cost share | |
| Tests | Laboratory Tests | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | $50 | | $100 | |
| Drugs to treat illness or condition | Generic drugs | $3 | | $5 | |
| | Preferred brand drugs | $5 | | $15 | X |
| | Non-preferred brand drugs | $10 | | $25 | X |
| | Specialty drugs | 10% | | 15% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | 10% | | 15% | |
| | Physician/surgeon fees | 10% | | 15% | |
| Need immediate attention | Emergency room services (waived if admitted) | $25 | | $75 | X |
| | Emergency medical transportation | $25 | | $75 | X |
| | Urgent care | $6 | | $30 | |
| Hospital stay | Facility fee (e.g. hospital room) | 10% | | 15% | X |
| | Physician/surgeon fee | | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | 10% | | 15% | X |
| | Substance use disorder outpatient services | $3 | | $15 | |
| | Substance use disorder inpatient services | 10% | | 15% | X |
| Pregnancy | Prenatal care and preconception visits | No cost share | | No cost share | |
| | Delivery and all inpatient services (Hospital / Professional) | 10% | | 15% | X |
| Help recovering or other special health needs | Home health care | $3 | | $15 | |
| | Outpatient Rehabilitation services | $3 | | $15 | |
| | Outpatient Habilitation services | $3 | | $15 | |
| | Skilled nursing care | 10% | | 15% | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No cost share | | No cost share | |
| Child eye care | Eye exam | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | No cost share | | No cost share | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | $25 | | $25 | |
| Child Dental Major Services | Root Canal- Molar | $300 | | $300 | |
| | Gingivectomy per Quad | $150 | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | $65 | | $65 | |
| | Extraction- Complete Bony | $160 | | $160 | |
| | Porcelain with Metal Crown | $300 | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | $1,000 | | $1,000 | |

See endnotes.

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### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Copay Plan 200%-250% FPL |
|---|---|
| Actuarial Value - AV Calculator | 73.50% |
| Individual Overall deductible | N/A |
| Other individual deductibles for specific services | |
| Medical | $1,600 |
| Brand Drugs | $250 |
| Dental | $0 |
| Individual Out-of-pocket maximum | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $40 | |
| | Specialist visit | | $50 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | |
| | Preferred brand drugs | | $35 | X |
| | Non-preferred brand drugs | | $60 | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | | |
| Help recovering or other special health needs | Home health care | | $40 | |
| | Outpatient Rehabilitation services | | $40 | |
| | Outpatient Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | $25 | |
| Child Dental Major Services | Root Canal- Molar | | $300 | |
| | Gingivectomy per Quad | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | | $65 | |
| | Extraction- Complete Bony | | $160 | |
| | Porcelain with Metal Crown | | $300 | |
| Child Orthodontics | Medically necessary orthodontics | | $1,000 | |

See endnotes.

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## Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Bronze Plan | Bronze HSA Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 60.60% | 59.40% |
| Individual Overall deductible | $5,000 integrated Med/Rx Ded | $4,500 integrated Med/Rx |
| Other individual deductibles for specific services | | |
| Medical | N/A | N/A |
| Brand Drugs | N/A | N/A |
| Dental | $0 | N/A |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $60 | After 1st three non-preventive visits | 40% | X |
| | Specialist visit | | $70 | X | 40% | X |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | 30% | X | 40% | X |
| | X-rays and Diagnostic Imaging | | 30% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs) | | 30% | X | 40% | X |
| Drugs to treat illness or condition | Generic drugs | | $15 | X | 40% | X |
| | Preferred brand drugs | | $50 | X | 40% | X |
| | Non-preferred brand drugs | | $75 | X | 40% | X |
| | Specialty drugs | | 30% | X | 40% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 30% | X | 40% | X |
| | Physician/surgeon fees | | 30% | X | 40% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | $300 | X | 40% | X |
| | Emergency medical transportation | | $300 | X | 40% | X |
| | Urgent care | | $120 | After 1st three non-preventive visits | 40% | X |
| Hospital stay | Facility fee (e.g. hospital room) | | 30% | X | 40% | X |
| | Physician/surgeon fee | | 30% | X | 40% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $60 | After 1st three non-preventive visits | 40% | X |
| | Mental/Behavioral health inpatient services | | 30% | X | 40% | X |
| | Substance use disorder outpatient services | | $60 | After 1st three non-preventive visits | 40% | X |
| | Substance use disorder inpatient services | | 30% | X | 40% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 30% | X | 40% | X |
| | | Professional | 30% | X | 40% | X |
| Help recovering or other special health needs | Home health care | | 30% | X | 40% | X |
| | Outpatient Rehabilitation services | | $60 | X | 40% | X |
| | Outpatient Habilitation services | | $60 | X | 40% | X |
| | Skilled nursing care | | 30% | X | 40% | X |
| | Durable medical equipment | | 30% | X | 40% | X |
| | Hospice service | | No cost share | X | No cost share | X |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam<br>Preventive - Cleaning<br>Preventive - X-ray<br>Sealants per Tooth<br>Topical Fluoride Application<br>Space Maintainers - Fixed | | No cost share | | No cost share | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | 20% | |
| Child Dental Major Services | Root Canal- Molar<br>Gingivectomy per Quad<br>Extraction- Single Tooth Exposed Root or Erupted<br>Extraction- Complete Bony<br>Porcelain with Metal Crown | | 50% | | 50% | |
| Child Orthodontics | Medically necessary orthodontics | | 50% | | 50% | |

See endnotes.

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**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Catastrophic Plan |
|---|---|
| Actuarial Value - AV Calculator | |
| Individual Overall deductible | $6,600 integrated Med/Rx Ded |
| Other Individual deductibles for specific services | |
| Medical | N/A |
| Brand Drugs | N/A |
| Dental | N/A |
| Individual Out-of-pocket maximum | $6,600 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | 0% | After 1st three non-preventive visits |
| | Specialist visit | | 0% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | 0% | X |
| | X-rays and Diagnostic Imaging | | 0% | X |
| | Imaging (CT/PET scans, MRIs) | | 0% | X |
| Drugs to treat illness or condition | Generic drugs | | 0% | X |
| | Preferred brand drugs | | 0% | X |
| | Non-preferred brand drugs | | 0% | X |
| | Specialty drugs | | 0% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 0% | X |
| | Physician/surgeon fees | | 0% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | 0% | X |
| | Emergency medical transportation | | 0% | X |
| | Urgent care | | 0% | After 1st three non-preventive visits |
| Hospital stay | Facility fee (e.g. hospital room) | | 0% | X |
| | Physician/surgeon fee | | 0% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health inpatient services | | 0% | X |
| | Substance use disorder outpatient services | | 0% | After 1st three non-preventive visits |
| | Substance use disorder inpatient services | | 0% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 0% | X |
| | | Professional | 0% | X |
| Help recovering or other special health needs | Home health care | | 0% | X |
| | Outpatient Rehabilitation services | | 0% | X |
| | Outpatient Habilitation services | | 0% | X |
| | Skilled nursing care | | 0% | X |
| | Durable medical equipment | | 0% | X |
| | Hospice service | | No cost share | X |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | x |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | X |
| Child Dental Major Services | Root Canal- Molar | | 50% | X |
| | Gingivectomy per Quad | | | X |
| | Extraction- Single Tooth Exposed Root or Erupted | | | X |
| | Extraction- Complete Bony | | | X |
| | Porcelain with Metal Crown | | | X |
| Child Orthodontics | Medically necessary orthodontics | | 50% | X |

See endnotes.

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**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of $2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
6) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month.
7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.
9) For the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental benefit design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to copays for non-preventive child dental benefits.

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COVERED CALIFORNIA™

## Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Platinum Coinsurance Plan | Platinum Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 88.10% | 88.00% |
| Individual Overall deductible | $0 | $0 |
| Other individual deductibles for specific services | | |
| Medical | $0 | $0 |
| Brand Drugs | $0 | $0 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $4,000 | $4,000 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $20 | | $20 | |
| | Specialist visit | | $40 | | $40 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $20 | | $20 | |
| | X-rays and Diagnostic Imaging | | $40 | | $40 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | $150 | |
| Drugs to treat illness or condition | Generic drugs | | $5 | | $5 | |
| | Preferred brand drugs | | $15 | | $15 | |
| | Non-preferred brand drugs | | $25 | | $25 | |
| | Specialty drugs | | 10% | | 10% | |
| Outpatient surgery | Facility fee (e.g., ASC) | | 10% | | $250 | |
| | Physician/surgeon fees | | 10% | | | |
| Need immediate attention | Emergency room services (waived if admitted) | | $150 | | $150 | |
| | Emergency medical transportation | | $150 | | $150 | |
| | Urgent care | | $40 | | $40 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 10% | | $250 per day up to 5 days | |
| | Physician/surgeon fee | | 10% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $20 | | $20 | |
| | Mental/Behavioral health inpatient services | | 10% | | $250 per day up to 5 days | |
| | Substance use disorder outpatient services | | $20 | | $20 | |
| | Substance use disorder inpatient services | | 10% | | $250 per day up to 5 days | |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 10% | | $250 per day up to 5 days | |
| | | Professional | 10% | | | |
| Help recovering or other special health needs | Home health care | | 10% | | $20 | |
| | Outpatient Rehabilitation services | | $20 | | $20 | |
| | Outpatient Habilitation services | | $20 | | $20 | |
| | Skilled nursing care | | 10% | | $150 per day up to 5 days | |
| | Durable medical equipment | | 10% | | 10% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | Not Covered | |
| | Extraction- Complete Bony | | | | Not Covered | |
| | Porcelain with Metal Crown | | | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

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**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Gold Coinsurance Plan | Gold Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 78.80% | 78.60% |
| Individual Overall deductible | $0 | $0 |
| Other Individual deductibles for specific services | | |
| Medical | $0 | $0 |
| Brand Drugs | $0 | $0 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $30 | | $30 | |
| | Specialist visit | | $50 | | $50 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $30 | | $30 | |
| | X-rays and Diagnostic imaging | | $50 | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | | $15 | |
| | Preferred brand drugs | | $50 | | $50 | |
| | Non-preferred brand drugs | | $70 | | $70 | |
| | Specialty drugs | | 20% | | 20% | |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | | $600 | |
| | Physician/surgeon fees | | 20% | | | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | | $250 | |
| | Emergency medical transportation | | $250 | | $250 | |
| | Urgent care | | $60 | | $60 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | | $600 per day up to 5 days | |
| | Physician/surgeon fee | | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $30 | | $30 | |
| | Mental/Behavioral health inpatient services | | 20% | | $600 per day up to 5 days | |
| | Substance use disorder outpatient services | | $30 | | $30 | |
| | Substance use disorder inpatient services | | 20% | | $600 per day up to 5 days | |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | | $600 per day up to 5 days | |
| | | Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | | 20% | | $30 | |
| | Outpatient Rehabilitation services | | $30 | | $30 | |
| | Outpatient Habilitation services | | $30 | | $30 | |
| | Skilled nursing care | | 20% | | $300 per day up to 5 days | |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | Not Covered | |
| | Extraction- Complete Bony | | | | Not Covered | |
| | Porcelain with Metal Crown | | | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
**Date: April 17, 2014**

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | Individual<br>Silver<br>Coinsurance Plan | Individual<br>Silver<br>Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 70.30% | 69.90% |
| Individual Overall deductible | N/A | N/A |
| Other Individual deductibles for specific services | | |
| Medical | $2,000 | $2,000 |
| Brand Drugs | $250 | $250 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | | $15 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam<br>Preventive - Cleaning<br>Preventive - X-ray<br>Sealants per Tooth<br>Topical Fluoride Application<br>Space Maintainers - Fixed | | Not Covered | | Not Covered | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | Not Covered | |
| | Extraction- Complete Bony | | | | Not Covered | |
| | Porcelain with Metal Crown | | | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
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| **Summary of Benefits and Coverage**<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | SHOP<br>Silver<br>Coinsurance Plan | SHOP<br>Silver<br>Copay Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 71.50% | 71.00% |
| Individual Overall deductible | N/A | N/A |
| Other individual deductibles for specific services | | |
| Medical | $1,500 | $1,500 |
| Brand Drugs | $500 | $500 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | | $15 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| Help recovering or other special health needs | Home health care | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam<br>Preventive - Cleaning<br>Preventive - X-ray<br>Sealants per Tooth<br>Topical Fluoride Application<br>Space Maintainers - Fixed | | Not Covered | | Not Covered | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | Not Covered | |
| | Extraction- Complete Bony | | | | Not Covered | |
| | Porcelain with Metal Crown | | | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
**Date: April 17, 2014**

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | SHOP<br>Silver HSA Plan |
|---|---|
| Actuarial Value - AV Calculator | 71.60% |
| Individual Overall deductible | $1,500 integrated Med/Rx Ded |
| Other individual deductibles for specific services | |
| Medical | N/A |
| Brand Drugs | N/A |
| Dental | N/A |
| Individual Out-of-pocket maximum | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | 20% | X |
| | Specialist visit | | 20% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | 20% | X |
| | X-rays and Diagnostic Imaging | | 20% | X |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| Drugs to treat illness or condition | Generic drugs | | 20% | X |
| | Preferred brand drugs | | 20% | X |
| | Non-preferred brand drugs | | 20% | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | 20% | X |
| | Emergency medical transportation | | 20% | X |
| | Urgent care | | 20% | X |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | 20% | X |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | 20% | X |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | X |
| Help recovering or other special health needs | Home health care | | 20% | X |
| | Outpatient Rehabilitation services | | 20% | X |
| | Outpatient Habilitation services | | 20% | X |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | X |
| | Hospice service | | No cost share | X |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | |
| | Gingivectomy per Quad | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | |
| | Extraction- Complete Bony | | | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
**Date: April 17, 2014**

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Coinsurance Plan 100%-150% FPL | Silver Coinsurance Plan 150%-200% FPL |
|---|---|---|
| Actuarial Value - AV Calculator | 94.80% | 88.00% |
| Individual Overall deductible | $0 | N/A |
| Other Individual deductibles for specific services | | |
| Medical | $0 | $500 |
| Brand Drugs | $0 | $50 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $2,250 | $2,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $3 | | $15 | |
| | Specialist visit | | $5 | | $20 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | 15% | X |
| Drugs to treat illness or condition | Generic drugs | | $3 | | $5 | |
| | Preferred brand drugs | | $5 | | $15 | X |
| | Non-preferred brand drugs | | $10 | | $25 | X |
| | Specialty drugs | | 10% | | 15% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 10% | | 15% | |
| | Physician/surgeon fees | | 10% | | 15% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $25 | | $75 | X |
| | Emergency medical transportation | | $25 | | $75 | X |
| | Urgent care | | $6 | | $30 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 10% | | 15% | X |
| | Physician/surgeon fee | | 10% | | 15% | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | | 10% | | 15% | X |
| | Substance use disorder outpatient services | | $3 | | $15 | |
| | Substance use disorder inpatient services | | 10% | | 15% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 10% | | 15% | X |
| | | Professional | 10% | | 15% | |
| Help recovering or other special health needs | Home health care | | 10% | | 15% | |
| | Outpatient Rehabilitation services | | $3 | | $15 | |
| | Outpatient Habilitation services | | $3 | | $15 | |
| | Skilled nursing care | | 10% | | 15% | X |
| | Durable medical equipment | | 10% | | 15% | |
| | Hospice service | | No cost share | | No cost share | |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | | |
| | Extraction- Complete Bony | | | | | |
| | Porcelain with Metal Crown | | | | | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
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### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Coinsurance Plan 200%-250% FPL |
|---|---|
| Actuarial Value - AV Calculator | rounded up to 74.0% |
| Individual Overall deductible | N/A |
| Other individual deductibles for specific services | |
| Medical | $1,600 |
| Brand Drugs | $250 |
| Dental | $0 |
| Individual Out-of-pocket maximum | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $40 | |
| | Specialist visit | | $50 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| Drugs to treat illness or condition | Generic drugs | | $15 | |
| | Preferred brand drugs | | $35 | X |
| | Non-preferred brand drugs | | $60 | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | |
| Help recovering or other special health needs | Home health care | | 20% | |
| | Outpatient Rehabilitation services | | $40 | |
| | Outpatient Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | |
| | Gingivectomy per Quad | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | |
| | Extraction- Complete Bony | | | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
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### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Copay Plan 100%-150% FPL | Silver Copay Plan 150%-200% FPL |
|---|---|---|
| Actuarial Value - AV Calculator | 94.90% | 88.00% |
| Individual Overall deductible | $0 | N/A |
| Other Individual deductibles for specific services | | |
| Medical | $0 | $500 |
| Brand Drugs | $0 | $50 |
| Dental | $0 | $0 |
| Individual Out-of-pocket maximum | $2,250 | $2,250 |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | $3 | | $15 | |
| | Specialist visit | $5 | | $20 | |
| | Preventive care/ screening/ immunization | No cost share | | No cost share | |
| Tests | Laboratory Tests | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | $50 | | $100 | |
| Drugs to treat illness or condition | Generic drugs | $3 | | $5 | |
| | Preferred brand drugs | $5 | | $15 | X |
| | Non-preferred brand drugs | $10 | | $25 | X |
| | Specialty drugs | 10% | | 15% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | 10% | | 15% | |
| | Physician/surgeon fees | 10% | | 15% | |
| Need immediate attention | Emergency room services (waived if admitted) | $25 | | $75 | X |
| | Emergency medical transportation | $25 | | $75 | X |
| | Urgent care | $6 | | $30 | |
| Hospital stay | Facility fee (e.g. hospital room) | 10% | | 15% | X |
| | Physician/surgeon fee | | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | 10% | | 15% | X |
| | Substance use disorder outpatient services | $3 | | $15 | |
| | Substance use disorder inpatient services | 10% | | 15% | X |
| Pregnancy | Prenatal care and preconception visits | No cost share | | No cost share | |
| | Delivery and all inpatient services (Hospital / Professional) | 10% | | 15% | X |
| Help recovering or other special health needs | Home health care | $3 | | $15 | |
| | Outpatient Rehabilitation services | $3 | | $15 | |
| | Outpatient Habilitation services | $3 | | $15 | |
| | Skilled nursing care | 10% | | 15% | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No cost share | | No cost share | |
| Child eye care | Eye exam | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | Not Covered | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | Not Covered | | Not Covered | |
| | Extraction- Complete Bony | Not Covered | | Not Covered | |
| | Porcelain with Metal Crown | Not Covered | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
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**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Copay Plan 200%-250% FPL |
|---|---|
| Actuarial Value - AV Calculator | 73.50% |
| Individual Overall deductible | N/A |
| Other Individual deductibles for specific services | |
| Medical | $1,600 |
| Brand Drugs | $250 |
| Dental | $0 |
| Individual Out-of-pocket maximum | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $40 | |
| | Specialist visit | | $50 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | $250 | |
| Drugs to treat illness or condition | Generic drugs | | $15 | |
| | Preferred brand drugs | | $35 | X |
| | Non-preferred brand drugs | | $60 | X |
| | Specialty drugs | | 20% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| Need immediate attention | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| Hospital stay | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | | |
| Help recovering or other special health needs | Home health care | | $40 | |
| | Outpatient Rehabilitation services | | $40 | |
| | Outpatient Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | |
| | Gingivectomy per Quad | | Not Covered | |
| | Extraction- Single Tooth Exposed Root or Erupted | | Not Covered | |
| | Extraction- Complete Bony | | Not Covered | |
| | Porcelain with Metal Crown | | Not Covered | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
**Date: April 17, 2014**

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Bronze Plan | Bronze HSA Plan |
|---|---|---|
| Actuarial Value - AV Calculator | 60.60% | 59.40% |
| Individual Overall deductible | $5,000 integrated Med/Rx Ded | $4,500 integrated Med/Rx |
| Other individual deductibles for specific services | | |
| Medical | N/A | N/A |
| Brand Drugs | N/A | N/A |
| Dental | $0 | N/A |
| Individual Out-of-pocket maximum | $6,250 | $6,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | $60 | After 1st three non-preventive visits | 40% | X |
| | Specialist visit | | $70 | X | 40% | X |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| Tests | Laboratory Tests | | 30% | X | 40% | X |
| | X-rays and Diagnostic Imaging | | 30% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs) | | 30% | X | 40% | X |
| Drugs to treat illness or condition | Generic drugs | | $15 | X | 40% | X |
| | Preferred brand drugs | | $50 | X | 40% | X |
| | Non-preferred brand drugs | | $75 | X | 40% | X |
| | Specialty drugs | | 30% | X | 40% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 30% | X | 40% | X |
| | Physician/surgeon fees | | 30% | X | 40% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | $300 | X | 40% | X |
| | Emergency medical transportation | | $300 | X | 40% | X |
| | Urgent care | | $120 | After 1st three non-preventive visits | 40% | X |
| Hospital stay | Facility fee (e.g. hospital room) | | 30% | X | 40% | X |
| | Physician/surgeon fee | | 30% | X | 40% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | $60 | After 1st three non-preventive visits | 40% | X |
| | Mental/Behavioral health inpatient services | | 30% | X | 40% | X |
| | Substance use disorder outpatient services | | $60 | After 1st three non-preventive visits | 40% | X |
| | Substance use disorder inpatient services | | 30% | X | 40% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | | No cost share | |
| | Delivery and all inpatient services | Hospital | 30% | X | 40% | X |
| | | Professional | 30% | X | 40% | X |
| Help recovering or other special health needs | Home health care | | 30% | X | 40% | X |
| | Outpatient Rehabilitation services | | $60 | X | 40% | X |
| | Outpatient Habilitation services | | $60 | X | 40% | X |
| | Skilled nursing care | | 30% | X | 40% | X |
| | Durable medical equipment | | 30% | X | 40% | X |
| | Hospice service | | No cost share | X | No cost share | X |
| Child eye care | Eye exam | | No cost share | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | | No cost share | |
| Child Dental Diagnostic and Preventive | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | | Not Covered | |
| | Gingivectomy per Quad | | | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | | |
| | Extraction- Complete Bony | | | | | |
| | Porcelain with Metal Crown | | | | | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs**
**9.5 EHB**
**Date: April 17, 2014**

### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | | | Catastrophic Plan | |
|---|---|---|---|---|
| Actuarial Value - AV Calculator | | | | |
| Individual Overall deductible | | | $6,600 integrated Med/Rx Ded | |
| Other individual deductibles for specific services | | | | |
| | Medical | | N/A | |
| | Brand Drugs | | N/A | |
| | Dental | | N/A | |
| Individual Out-of-pocket maximum | | | $6,600 | |
| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
| Health care provider's office or clinic visit | Primary care visit or non-specialist practitioner visit to treat an injury or illness | | 0% | After 1st three non-preventive visits |
| | Specialist visit | | 0% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| Tests | Laboratory Tests | | 0% | X |
| | X-rays and Diagnostic Imaging | | 0% | X |
| | Imaging (CT/PET scans, MRIs) | | 0% | X |
| Drugs to treat illness or condition | Generic drugs | | 0% | X |
| | Preferred brand drugs | | 0% | X |
| | Non-preferred brand drugs | | 0% | X |
| | Specialty drugs | | 0% | X |
| Outpatient surgery | Facility fee (e.g., ASC) | | 0% | X |
| | Physician/surgeon fees | | 0% | X |
| Need immediate attention | Emergency room services (waived if admitted) | | 0% | X |
| | Emergency medical transportation | | 0% | X |
| | Urgent care | | 0% | After 1st three non-preventive visits |
| Hospital stay | Facility fee (e.g. hospital room) | | 0% | X |
| | Physician/surgeon fee | | 0% | X |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health inpatient services | | 0% | X |
| | Substance use disorder outpatient services | | 0% | After 1st three non-preventive visits |
| | Substance use disorder inpatient services | | 0% | X |
| Pregnancy | Prenatal care and preconception visits | | No cost share | |
| | Delivery and all inpatient services | Hospital | 0% | X |
| | | Professional | 0% | X |
| Help recovering or other special health needs | Home health care | | 0% | X |
| | Outpatient Rehabilitation services | | 0% | X |
| | Outpatient Habilitation services | | 0% | X |
| | Skilled nursing care | | 0% | X |
| | Durable medical equipment | | 0% | X |
| | Hospice service | | No cost share | X |
| Child eye care | Eye exam | | No cost share | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No cost share | x |
| Child Dental Diagnostic and Preventive | Oral Exam | | No cost share | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| Child Dental Major Services | Root Canal- Molar | | Not Covered | |
| | Gingivectomy per Quad | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | |
| | Extraction- Complete Bony | | | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodontics | | Not Covered | |

See endnotes.

**2015 Standard Benefit Plan Designs 9.5 EHB**

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of $2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
6) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month.
7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.

COVERED CALIFORNIA™

## 2015 Dental Standard Benefit Plan Designs

### Date: April 17, 2014

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Standalone Dental Plan<br>Pediatric Dental EHB Copay Plan | Standalone Dental Plan<br>Pediatric Dental EHB Coinsurance Plan |
|---|---|---|
| | Up to Age 19 | Up to Age 19 |
| Actuarial Value | 83.0% | 86.8% |
| Individual Deductible (waived for Diagnostic & Preventive) | $0 | $65 In Network/<br>$65 Out of Network |
| Family Deductible (Two or more children) (waived for Diagnostic & Preventive) | $0 | $130 In Network/<br>$130 Out of Network |
| Individual Out of Pocket Maximum | $350 | $350 |
| Family Out of Pocket Maximum (Two or More Children) | $700 | $700 |
| Office Copay | $0 | $0 |
| Waiting Period<br>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a) 3)(3)(4) and Insurance Code 10198.6 (10)(e)) | None | None |
| Annual Benefit Limit<br>(the maximum amount the dental plan will pay in the benefit year) | None | None |

| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Diagnostic & Preventive | Oral Exam | $0 | | 0% | |
| | Preventive - Cleaning | $0 | | 0% | |
| | Preventive - X-ray | $0 | | 0% | |
| | Sealants per Tooth | $0 | | 0% | |
| | Topical Fluoride Application | $0 | | 0% | |
| | Space Maintainers - Fixed | $0 | | 0% | |
| Basic Services | Amalgam Fill - One Surface | $25 | | 20% | x |
| Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery | Root Canal - Molar | $300 | | 50% | x |
| | Gingivectomy per Quad | $150 | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | $65 | | | |
| | Extraction - Complete Bony | $160 | | | |
| | Crown - Porcelain with Metal | $300 | | | |
| Orthodontia | Medically Necessary Orthodontia | $350 | | 50% | x |

**Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)**

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

**Adult Dental Benefit Notes (only applicable to the Family Dental Plan)**

5) Each adult is responsible for an individual deductible.
6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

COVERED CALIFORNIA™

## 2015 Dental Standard Benefit Plan Designs

### Date: April 17, 2014

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Family Dental Plan | |
|---|---|---|
| | Pediatric Dental EHB Copay Plan | Adult Dental Copay Plan |
| | Up to Age 19 | Age 19 and Older |
| Actuarial Value | 83.0% | Not Calculated |
| Individual Deductible (waived for Diagnostic & Preventive) | $0 | $0 |
| Family Deductible (Two or more children) (waived for Diagnostic & Preventive) | $0 | $0 |
| Individual Out of Pocket Maximum | $350 | Not Applicable |
| Family Out of Pocket Maximum (Two or More Children) | $700 | Not Applicable |
| Office Copay | $0 | $0 |
| Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1367.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)) | None | None |
| Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) | None | None |

| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Diagnostic & Preventive | Oral Exam | $0 | | $0 | |
| | Preventive - Cleaning | $0 | | $0 | |
| | Preventive - X-ray | $0 | | $0 | |
| | Sealants per Tooth | $0 | | Not Covered | |
| | Topical Fluoride Application | $0 | | Not Covered | |
| | Space Maintainers - Fixed | $0 | | Not Covered | |
| Basic Services | Amalgam Fill - One Surface | $25 | | $25 | |
| Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery | Root Canal - Molar | $300 | | $300 | |
| | Gingivectomy per Quad | $150 | | $150 | |
| | Extraction- Single Tooth Exposed Root or Erupted | $65 | | $65 | |
| | Extraction - Complete Bony | $160 | | $160 | |
| | Crown - Porcelain with Metal | $300 | | $300 | |
| Orthodontia | Medically Necessary Orthodontia | $350 | | Not Covered | |

**Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)**

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

**Adult Dental Benefit Notes (only applicable to the Family Dental Plan)**

5) Each adult is responsible for an individual deductible.
6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

COVERED CALIFORNIA™

## 2015 Dental Standard Benefit Plan Designs

### Date: April 17, 2014

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Family Dental Plan | |
|---|---|---|
| | Pediatric Dental EHB Coinsurance Plan | Adult Dental Coinsurance Plan |
| | Up to Age 19 | Age 19 and Older |
| Actuarial Value | 86.8% | Not Calculated |
| Individual Deductible (waived for Diagnostic & Preventive) | $65 In Network/ $65 Out of Network | $50 In Network/ $50 Out of Network |
| Family Deductible (Two or more children) (waived for Diagnostic & Preventive) | $130 In Network/ $130 Out of Network | Not Applicable |
| Individual Out of Pocket Maximum | $350 | Not Applicable |
| Family Out of Pocket Maximum (Two or More Children) | $700 | Not Applicable |
| Office Copay | $0 | $0 |
| Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1367.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)) | None | 6 months for Major Services, Waived with Proof of Prior Coverage |
| Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) | None | $1,500 |

| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| Diagnostic & Preventive | Oral Exam | 0% | | 0% | |
| | Preventive - Cleaning | 0% | | 0% | |
| | Preventive - X-ray | 0% | | 0% | |
| | Sealants per Tooth | 0% | | Not Covered | |
| | Topical Fluoride Application | 0% | | Not Covered | |
| | Space Maintainers - Fixed | 0% | | Not Covered | |
| Basic Services | Amalgam Fill - One Surface | 20% | x | 20% | x |
| Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery | Root Canal - Molar | 50% | x | 50% | x |
| | Gingivectomy per Quad | | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | |
| | Extraction - Complete Bony | | | | |
| | Crown - Porcelain with Metal | | | | |
| Orthodontia | Medically Necessary Orthodontia | 50% | x | Not Covered | |

**Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)**

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

**Adult Dental Benefit Notes (only applicable to the Family Dental Plan)**

5) Each adult is responsible for an individual deductible.
6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.